

APPENDIX 12

INSTRUCTIONS FOR THE COMPLETION OF THE  
PRIOR AUTHORIZATION EVALUATION AND TESTING ATTACHMENT  
(PA/ETA)

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The information contained on the Prior Authorization Evaluation and Testing (PA/ETA) Attachment will be used to make a decision about the amount and type of evaluation and testing which will be approved for Medical Assistance reimbursement. Please complete each section as completely as possible and include any material which you believe will be of help in understanding the necessity for the services you are requesting. Where noted in these instructions, you may substitute material which you may have in your records for the information requested on the form. The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted. Complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

EDS  
Prior Authorization Unit  
Suite 88  
6406 Bridge Road  
Madison, WI 53784-0088

When the provider performing the evaluation or testing services will also be providing psychotherapy services or when the psychotherapy provider is employed by the same agency as the person providing the evaluation or testing and both will be billed by that agency, the prior authorization psychotherapy attachment must be submitted along with the PA/ETA. One PA/RF may be used indicating the appropriate procedure codes for all requested services. This will simplify future billing by having all services under one prior authorization number which may then be billed on the same claim form.

However, if the evaluation or testing is being performed by a provider whose services are not being billed by the same agency, then separate PA/RFs must be submitted with the appropriate attachments. In these cases, a separate prior authorization number is assigned for the evaluation or testing services and the psychotherapy services, and the services will need to be billed on separate claim forms.

Questions regarding the completion of the PA/RF and/or the PA/ETA may be addressed to EDS' Telephone/Written Correspondence Unit.

RECIPIENT INFORMATION

ELEMENT 1 - RECIPIENT'S LAST NAME

Enter the recipient's last name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 2 - RECIPIENT'S FIRST NAME

Enter the recipient's first name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL

Enter the recipient's middle initial exactly as it appears on the recipient's Medical Assistance Identification card.

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER

Enter the recipient's 10-digit Medical Assistance identification number exactly as it appears on the recipient's Medical Assistance identification card.

**ELEMENT 5 - RECIPIENT'S AGE**

Enter the age of the recipient in numerical form (e.g., 21, 45, 60, etc.).

**PROVIDER INFORMATION**

**ELEMENT 6 - PERFORMING PROVIDER NAME**

Enter the name of the therapist who will be performing the evaluation or testing.

**ELEMENT 7 - PERFORMING PROVIDER NUMBER**

Enter the eight-digit Medical Assistance provider number of the performing provider. (Not required for providers in 51.42 Board-operated clinics.)

**ELEMENT 8 - PERFORMING PROVIDER TELEPHONE NUMBER**

Enter the telephone number, including area code, of the performing provider.

**ELEMENT 9 - PERFORMING PROVIDER CREDENTIALS**

Indicate the credentials of the performing provider.

**DOCUMENTATION**

**A. TYPE OF EVALUATION/TESTING AND RATIONALE**

Document the type of evaluation being requested and why it is needed. For instance, the evaluation may be a competency examination or it may be necessitated by the need to confirm a diagnosis. If the recipient was referred for evaluation, indicate who made the referral and why. Indicate how the results of the evaluation or testing will be used. Indicate how the recipient will benefit (e.g., indicate if the evaluation might be used to place the recipient in a less restrictive setting, or to obtain guardianship which would be in the recipient's best interests). **Providers requesting retroactive authorization must document the emergency situation or the court order that justifies such a request and indicate the initial date of service.**

**B. TECHNIQUES OR INSTRUMENTS TO BE USED**

Indicate the specific tests, instruments or procedures which will be used to conduct the testing or evaluation. These tests, instruments or procedures must be those accepted as standard of practice for the psychiatrist/psychologist (e.g., proposed psychological testing instruments should be listed in the latest edition of the Mental Measurements Handbook).

**C. OTHER EVALUATIONS**

The provider needs to indicate what other evaluations or testing they are aware of that have been done on the recipient in the past two years and why the current request is not duplicative. Where possible attach copies of the evaluations or tests or summaries of their results.

**A physician's prescription is not required for these evaluation and testing services.**